U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 10Apr2002

In the Matter of:	:	
	:	
LINCUS BAKER,	:	
Claimant,	:	
	:	
v.	:	CASE NO.: 2000-BLA-00045
	:	
DANNY LARGE TRUCKING, INC.,	:	
Employer,	:	
	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS'	:	
COMPENSATION PROGRAMS,	:	
Party-in-Interest	:	

Appearances:

Joseph E. Wolfe, Esq.
For the Claimant

Michael F. Blair, Esq.
For the Employer

Before: Edward Terhune Miller
Administrative Law Judge

DECISION AND ORDER - REJECTION OF CLAIM

Statement of the Case

This case involves a claim for federal benefits under the Black Lung Benefits Act (the Act), and

applicable federal regulations[1]. The Act and regulations provide compensation and other benefits, *inter alia*, to living coal miners who are totally disabled due to pneumoconiosis and to their dependents. The Act and regulations define pneumoconiosis ("black lung disease" or "coal workers' pneumoconiosis") as a chronic dust disease of the lungs and its sequellae, including respiratory and pulmonary impairments arising out of coal mine employment.[2] The definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis, and "includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. §718.201.This proceeding involves a first claim for benefits under the Act, as amended. Since Claimant filed an application for benefits after January 1, 1982, Part 718 applies. Because the Claimant miner was last employed in the coal mine industry in Kentucky, the law of the United States Court of Appeals for the Sixth Circuit controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989)(*en banc*). In order to obtain federal black lung benefits, a claimant must prove by a preponderance of the evidence that: "(1) he has pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) he has a totally disabling respiratory or pulmonary condition; and (4) pneumoconiosis is a contributing cause to his total respiratory disability." *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 529, 21 BLR 2-323 (4th Cir. 1998); *Gee v. W.G. Moore & Sons*, 9 BLR 1-4 (1986).

Procedural History

The Claimant miner, Lincus Baker, filed this application for benefits on August 28, 1997 (DX 1). The District Director issued an initial determination that Claimant was eligible for benefits on February 23,

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[1] All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, and are cited by part or section only.

[2]The Department of Labor has amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended (the Black Lung Benefits Act). These regulations became effective on January 19, 2001, and were published at 65 Fed. Reg. 80,045-80, 107 (2000)(to be codified at 20 CFR Parts 718, 722, 725, and 726). All citations to the regulations, unless otherwise indicated, refer to the amended regulations. Pursuant to a lawsuit challenging revisions to forty-seven of the regulations implementing the Act, the United States District Court for the District of Columbia granted limited injunctive relief for the duration of the lawsuit, and stayed, inter alia, all claims pending, except for those which, after briefing by the parties to the claim, were determined not to be impacted as to outcome by the regulations at issue in the lawsuit. *National Mining Ass'n v. Chao*, No. 1:00CV03086 (D.D.C. Feb. 9, 2001)(order granting preliminary injunction). This tribunal subsequently issued an order dated February 27, 2001, requesting supplemental briefing in this case, to which the parties duly responded. On August 9, 2001, the District Court issued its decision upholding the validity of the challenged regulations and dissolving the February 9, 2001, order granting the preliminary injunction. *National Mining Ass'n v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). The court's decision renders moot the contentions of the parties with respect to the impact of the challenged regulations in this case.

1998 (DX 29A). At that time, several employers were listed as possible responsible operators, and the claim was controverted in March 1998 (DX 31-33). On June 10, 1998, the District Director notified three putative responsible operators of his determination that Claimant was eligible for benefits (DX 37, 38, 39). The determination was controverted, and referral for hearing was requested on June 17, 1998 (DX 40, 41). The claim was referred to the Office of Administrative Law Judges on July 28, 1998 (DX 44), but remanded by Administrative Law Judge Richard Morgan by order dated March 11, 1999, for development of medical evidence and for identification of the responsible operator (DX 83). On July 12, 1999, the District Director named Danny Large Trucking, Inc. as the responsible operator (DX 90). The District Director notified Employer that he had found Claimant eligible for benefits on August 12, 1999 (DX 98). Employer requested a hearing on August 25, 1999, and the claim was referred to the Office of Administrative Law Judges on October 12, 1999 (DX 99,100). A formal hearing was conducted by this tribunal in Abingdon, Virginia on March 8, 2000, at which time all parties were afforded a full opportunity to present evidence and argument.[3]

Issues

(1) Whether certain evidence obtained by allegedly unlicensed technicians and a physician allegedly not licensed to practice medicine in Kentucky, where the procedures were performed, should be excluded from the record or given reduced or no probative weight?

(2) Whether the miner has pneumoconiosis?

(3) Whether, if proved, the pneumoconiosis arose out of coal mine employment?

(4) Whether the miner is totally disabled?

(5) Whether, if so, the disability is due to pneumoconiosis?

Objection to Admissibility of Certain Medical Evidence

At the hearing Claimant initially objected to the admission of pulmonary function test results

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[3]Citations to the transcript of the hearing are denoted "Tr." At the hearing, Director's Exhibits ("DX") 1-33, 35-72, and 74-101 were admitted into evidence without objection (Tr. 5-35). A determination on Claimant's objection to Director's Exhibits 34 and 73 was deferred (Tr. 5-35). Claimant's Exhibits 1-4 were admitted into evidence, but Claimant's proffered Exhibits CA and CB for identification were excluded but lodged (Tr. 37, 74-75). Employer's exhibits ("EX") 1-21 were admitted without objection , but a ruling with respect to Claimant's objection and the admissibility of Employer's Exhibit 22 was deferred (Tr. 76). Claimant was represented by counsel, and testified at the hearing, (Tr. 39-72).

obtained by a laboratory technician McGrath, who was alleged not to be licensed as required at the time by the state of Kentucky. The tests were part of an examination by Dr. Fino on April 21, 1998, at the Landmark Motel in Pikeville, Kentucky. (Tr. 6-7, 8-9, 27, 47, 65; DX 34) Claimant subsequently testified he was examined in a motel room in Kentucky by Dr. Fino, who had apparently set up a temporary clinic there (Tr. 47-48). He said that Dr. Fino asked him a few questions, but did not do any physical examination (Tr. 48-49). Employer stipulated that an examination took place on April 21, 1998, in Kentucky. (Tr. 8, 27) Claimant subsequently expanded the scope of his objection to seek exclusion of the entire medical opinion report and the deposition of Dr. Fino, because Claimant alleges that Dr. Fino was not licensed to practice medicine in the state of Kentucky at that time, that the laboratory technician was not licensed in Kentucky, where the examination and testing allegedly took place, and because the examination was in substantial part the subject of the deposition.[4] (Tr. 17-19, 23-24) However, the statutory or regulatory medical licensing requirements, if any, applicable in Kentucky are not in evidence or otherwise of record in this case. Because of Claimant's objection, admission into evidence of the exhibits containing Dr. Fino's examination report and the related pulmonary function results (DX 34), and the transcript of Dr. Fino's deposition (EX 22), was deferred. (Tr. 34-35, 79-80) However, Claimant expressly did not object to the admission of Dr. Fino's curriculum vitae attached to the deposition which, in the absence of any other objection, is admitted into evidence. (Tr. 23-26, 77-79; EX 22) Claimant's objection to Dr. Fino's x-ray interpretations was abandoned by the Claimant, and so EX 1 and DX 73 in its entirety are properly admitted in evidence. (Tr. 27, 29-33, 77-78, 80; DX 73; EX 1)

Employer contended that nothing in the black lung program requires certification of technicians, and contended, citing a prior ALJ decision, that any valid objection would not require exclusion from evidence, but should affect the probative weight to be assigned to the evidence. (Tr.9, 18, 22-23)

To support his objection, Claimant also sought to introduce at the hearing two letters purportedly from Kentucky agencies, which he alleged would establish that the laboratory technician McGrath and Dr. Fino were not licensed to perform the relevant medical procedures in Kentucky at the time of the examination on April 21, 1998. The documents were excluded from evidence as not having been timely exchanged in accordance with the so-called twenty-day rule, and in the absence of consent or a showing of good cause. §725.456(b) At Claimant's request the documents were lodged as part of the record. (Tr. 16-17, 19, 21-22, 74-75; C-A, C-B)

Dr. Fino's curriculum vitae attached to his deposition is properly admitted into evidence in the absence of objection. (EX 22) It discloses affirmatively that Dr. Fino was licensed to practice medicine in Pennsylvania, as stipulated by Claimant, and by negative implication that Dr. Fino was not so licensed

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[4]Because of the changed scope of Claimant's evidentiary objections, Employer ultimately declined to stipulate that Dr. Fino and the laboratory technician McGrath were not licensed in Kentucky, and put Claimant to his proof. (Tr. 18-19, 23-27) Claimant did not, as he proposed, brief his contention that a claimant's challenge to the licensure of any professional shifts the burden of proving licensed status to the respondent. (Tr. 73)

by Kentucky (DX 34; part of E-22; Tr.28) Claimant stipulated that Dr. Fino was licensed to practice medicine in Pennsylvania. Claimant testified that he had been advised by telephone by a woman, who was alleged to be at the Kentucky Board of Medical Licensure, but refused to disclose her name, that Dr. Fino was not licensed in Kentucky. (Tr. 53-55) The testimony was not barred pursuant to Employer's objection on the grounds of competence or its nature as hearsay. (Tr. 72-73) However, the vagueness of the testimony, its hearsay nature, Claimant's inability to identify the information source, and the fact that the testimony, such as it was, was adduced in substantial part in response to leading questions, impairs its reliability to such an extent that it is discredited by this tribunal. (Tr. 39, 52-55, 67-68, 72-73)

The evidence in Dr. Fino's curriculum vitae that he was not licensed in Kentucky at the time of the April 21, 1998, examination and testing is uncontradicted by evidence. Claimant's assertion that the laboratory technician McGrath was unlicensed in Kentucky, however, is unsupported by any credible evidence, and so is unproved. Notwithstanding, there is no evidence in this record that such doctors or technicians must be licensed in Kentucky to perform the functions in issue in this case. The burden of proof normally would rest with the proponent, and Claimant has not shown the contrary in respect of this issue. It follows that there is a failure of proof necessary to support Claimant's objection to the admissibility in evidence of Dr. Fino's report and deposition testimony, including the results of the pulmonary function tests administered by McGrath. Although a case can be made that in black lung cases such as this, evidence generated by medical professionals who have not satisfied applicable licensing or other pertinent requirements for medical practice in the state where their functions are performed may be excluded or discredited, see the analysis, reasoning, and conclusions advanced by Judge Levin in *Carl H. Maggard v. Dominion Coal Co.*, 22 BLR 3-70 (2000) with respect to a similar challenge, the necessary premises for such an exclusion or discreditation have not been established in this case. Claimant's objection to the admission and consideration of Dr. Fino's examination report and opinion, as well as his deposition testimony and the results of the pulmonary function study performed by the technician McGrath, therefore, must be overruled.[5]

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[5]In support of its contention that the evidence should not be excluded, Employer relied upon an Order dated February 3, 2000, filed in *Leonard M. Rasnick v. Lambert Coal Company, Inc., 1999-BLA-1131*, in which Administrative Law Judge Jansen found that the evidence pertaining to the state certification of administering pulmonary function study technicians was not relevant because there is no regulatory requirement pertaining to the certification of the technician. Judge Jansen declared, "It is for the medical physicians who review the procedure and test results to determine whether the tests conform to the standards outlined in Appendix B. The results of the medical reviews determine the weight to be given to the test results." Judge Levin, on the other hand, has concluded that, notwithstanding the relevance of the evidence in issue, "the use of evidence garnered by a health professional during an examination performed in violation of state licensing requirements in adjudicative proceedings against the examined claimant, undermines the integrity of both the claim development process and the subsequent administrative adjudications." Judge Levin reasoned that silence of the Department of Labor's applicable regulations regarding state licensing requirements for the practice of medicine does not imply that black lung examinations may be performed in a manner inconsistent with

Findings of Fact

Coal Miner Status; Length of Coal Mine Employment

Employer stipulated that Claimant was a coal miner within the meaning of Section 402(d) of the Act and Section 725.202 of the Regulations for at least twenty-five (25) years (Tr. 36). Claimant testified he worked in coal mine employment for forty-seven years, twenty-five years below ground and almost twenty years trucking coal. He started in 1948 working outside small mines hauling supplies when he was fifteen, but he started working underground at age seventeen driving a sting team of mules hauling coal out of the mine. Subsequently, he worked at the face of small mines, shooting coal, loading coal, until he got his job at Westmoreland Coal approximately 1967. His employment history shows that he worked underground as a repairman for Westmoreland Coal and then in a mine for Bethlehem Steel. After about 1978 until July 1994, when he quit because he was short of breath and unable to work, he trucked coal from a stock pile directly outside of a coal mine to the processing plant where the coal was put in a crusher or on the ground (Tr. 39-45; DX 2) The work involved extensive dust exposure and hard labor. Claimant's Social Security Earnings Statement, considered in light of his testimony, establishes thirty-eight years of coal mine employment (DX 4).

Responsible Operator

Employer, Danny Large Trucking, Inc., does not contest its designation as responsible operator liable for payment of any benefits which may be found to be due to the Claimant, and so is the properly designated respondent in this case (Tr. 36).

Background, Dependents, and Employment History

Claimant was born on April 16, 1932, and was 68 years old at the time of the hearing (DX 1; Tr. 39). Claimant has established one dependent for purposes of potential augmentation of benefits, his wife, Stella Mullins, whom he married on August 7, 1957 (DX 9).

Medical Evidence

Claimant testified he is currently being treated by Dr. Wheatley with breathing medications and he was recently hospitalized for his breathing problems (Tr. 62-63). Claimant testified that he began smoking

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lawful medical practice in the jurisdiction in which they are scheduled. Thus, he concluded, such evidence should be excluded from the record as an exception to the rubric in *U.S. Steel Mining Co. v. Director, OWCP*, [Jarrell], 787 F.3d 384, 21 BLR 2-639 (4th Cir. 1999), or should be accorded no weight, if obtained by an employer contrary to public policy.

in his twenties and quit in 1988. Since he smoked off and on over the years, he testified he smoked about twenty-four years in all (Tr. 63). He has been diagnosed as a diabetic, stage number 2 for two to three years, but does not require insulin. Claimant testified that he had had recent surgery for cancer of the bladder (Tr. 65).

Chest X-ray Evidence[6]

Exhibit No.	Date of x-ray	Date of Report	Physician/ Qualifications	Diagnosis
EX 19	04-15-92	04-24-02	Goplan	Minimal residual changes
EX 20	05-19-92	05-19-92	Goplan	Clearing of previous infiltrate
EX 16	05-19-92	10-02-98	Scott, B/R	No pneumoconiosis, emphysema
EX 17	05-19-92	10-07-98	Wheeler, B/R	No pneumoconiosis, emphysema
EX 21	08-27-92	08-27-92	Goplan	No acute cardio-pulmonary disease
EX 14	08-27-92	10-02-98	Scott, B/R	No pneumoconiosis, emphysema
EX 15	08-27-92	10-07-98	Wheeler, B/R	No pneumoconiosis, emphysema
EX 12	03-31-93	10-02-98	Scott, B/R	No pneumoconiosis, emphysema
EX 13	03-31-93	10-07-98	Wheeler, B/R	No pneumoconiosis, emphysema
EX 10	07-28-94	10-02-98	Scott, B/R	No pneumoconiosis, emphysema
EX 11	07-28-94	10-07-98	Wheeler, B/R	No pneumoconiosis, emphysema
DX 49	08-30-94	07-30-98	Dahhan, B	Completely negative
DX 61	08-30-94	09-03-98	Scott, B/R	No pneumoconiosis
DX 61	08-30-94	09-05-98	Wheeler, B/R	No pneumoconiosis

[6] The following abbreviations are used in describing the qualifications of the physicians: B = B-Reader, R=Board-certified Radiologist.

Exhibit No.	Date of x-ray	Date of Report	Physician/ Qualifications	Diagnosis
DX 17	10-01-97	10-01-97	Paranthaman, B	0/1 s, s
DX 18	10-01-97	11-14-97	Navani, B	1/0 p, s, emphysema
DX 16	10-01-97	02-04-98	Lippman, B	1/0 s, t
DX 35	10-01-97	04-29-98	Dahhan, B	Completely negative
DX 35	10-01-97	05-20-98	Wiot, B/R	Completely negative
DX 36	10-01-97	06-09-98	Shipley, B/R	Completely negative
DX 48	10-01-97	06-18-98	Spitz, B/R	Completely negative
DX 54	10-01-97	08-26-98	Scott, B/R	Completely negative
DX 54	10-01-97	08-31-98	Wheeler, B/R	Completely negative
EX 1	10-01-97	10-02-98	Fino, B	Completely negative
EX 8	02-10-98	10-02-98	Scott, B/R	No pneumoconiosis, emphysema
EX 9	02-10-98	10-07-98	Wheeler, B/R	No pneumoconiosis, emphysema
DX 55	04-14-98	08-29-98	Wiot, B/R	Completely negative
DX 56	04-14-98	09-01-98	Spitz, B/R	No pneumoconiosis
DX 63	04-14-98	09-08-98	Shipley, B/R	Completely negative
DX 34	04-21-98	04-26-98	Fino, B	Completely negative
DX 47	04-21-98	06-29-98	Dahhan, B	Completely negative
DX 47	04-21-98	07-28-98	Scott, B/R	No pneumoconiosis, emphysema
DX 47	04-21-98	07-28-98	Wheeler, B/R	No pneumoconiosis, emphysema
EX 6	06-12-98	10-02-98	Scott, B/R	No pneumoconiosis, emphysema
EX 7	06-12-98	10-07-98	Wheeler, B/R	No pneumoconiosis, emphysema
EX 4	08-21-98	10-02-98	Scott, B/R	No pneumoconiosis, emphysema
EX 5	08-21-98	10-07-98	Wheeler, B/R	No pneumoconiosis, emphysema
EX 2	08-28-98	10-02-98	Scott, B/R	No pneumoconiosis, emphysema

Exhibit No.	Date of x-ray	Date of Report	Physician/ Qualifications	Diagnosis
EX 3	08-28-98	10-07-98	Wheeler, B/R	No pneumoconiosis, emphysema
CX 1	08-28-98	01-26-00	Aycoth, B/R	2/2 q, p
DX 35	10-14-98	10-14-98	Dahhan, B	No pneumoconiosis, emphysema
DX 94	01-22-99	01-22-99	Robinette, B	1/1 q, t, emphysema, right middle lung collapse
DX 94	01-22-99	01-25-99	Humphreys	coal workers' pneumoconiosis, left upper lobe nodule
DX 84	01-22-99	03-31-99	Fino, B	no pneumoconiosis, diffuse fibrosis
DX 84	01-22-99	04-06-99	Wheeler, B/R	No pneumoconiosis, granuloma
DX 84	01-22-99	04-06-99	Scott, B/R	No pneumoconiosis, granuloma, 5 mm left apex
CX 2	01-22-99	10-26-00	Aycoth, B/R	2/3 q, t
CX 2	01-22-99	01-28-00	Cappiello, B/R	2/3 q, p, coalescence of right lung, emphysema

Pulmonary Function Studies

Exhibit No.	Date of Test	Height	Age	Conform	FEV-1	MVV	FVC	Qualify
DX 11 *	10-07-97	68"	65	Yes	0.94 1.20	36 55	2.48 2.73	Yes Yes
DX 35 *	04-14-98	68"	66	Yes	1.25 1.56	38 43	2.65 3.35	Yes Yes
DX 94 *	01-22-99	70"	66	Yes	1.19 1.45	--- ---	2.65 3.41	Yes Yes

* Denotes post bronchodilator study

Arterial Blood Gas Studies

Exhibit No.	Test Date	pCO_2	pO_2	Qualify
DX 14	10-01-97	51.0	58.0	Yes
DX 35	04-14-98	59.9	43.1	Yes
DX 94	01-22-99	51.0	46.2	Yes

Medical Reports/Opinions

Claimant was examined on October 1, 1997 on behalf of the Department of Labor by Dr. Paranthaman, board-certified in internal medicine and the subspecialties of critical care medicine, geriatric medicine, and pulmonary disease, who reported an increased AP diameter, breath sounds markedly diminished, and bilateral wheezing.[7] He recorded a smoking history of twenty years, a half-pack of filtered cigarettes per day, ending ten years prior to the examination, which would have been 1987. He noted a chest x-ray classified with respect to pneumoconiosis as 0/1 s/s, and conducted pulmonary function and resting arterial blood gas studies. He diagnosed pulmonary emphysema and reactive airway disease, and opined that Claimant's pulmonary emphysema, but not the reactive airway disease, was primarily due to his history of smoking for twenty years. Dr. Paranthaman attributed neither condition to coal dust exposure, but opined that "[b]oth conditions could have been significantly aggravated by coal dust exposure for 44 years, if documented." He recorded an employment history of twenty-seven years underground, and twenty years driving a truck hauling coal ending in 1994 due to breathing problems. He opined at that time that Claimant was totally disabled from his last coal mine employment as repairman, electrician since his FEV_1 and arterial blood gas results met total disability standards under the Act. (DX 11, 13, 14) Both the ventilatory studies and the resting arterial blood gas study were validated by Dr. Michos on October 31, 1997 (DX 15).

On February 2, 1998, Dr. Paranthaman opined further that simple coal workers' pneumoconiosis could be diagnosed, based on his prior examination, notwithstanding the fact that the District Director was able to verify only sixteen years of coal mining employment ending in 1994, and based on two positive chest x-ray readings of pneumoconiosis, 1/0, by Drs. Navani and Lippman, physicians certified as B-readers. He reiterated his earlier finding that the pulmonary function tests showed very severe airway obstruction, and that the arterial blood gas tests showed CO_2 retention and moderate hypoxemia, which would totally disable Claimant for underground work as well as work as a truck driver due to the respiratory impairment. Dr. Paranthaman declared that the severe degree of pulmonary emphysema and presence of reactive airway disease as shown by a twenty-seven percent improvement in FEV1 in the post bronchodilator study are uncommon in cases of coal workers' pneumoconiosis. Consequently, Dr. Paranthaman reiterated his conclusion that cigarette smoking for twenty years was the primary cause of Claimant's pulmonary

[7]The professional credentials of Dr. Paranthaman are not in evidence. However, this tribunal takes judicial notice that his relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

emphysema, and that the reactive airway disease was not related to coal dust exposure. He opined that sixteen years of coal mine employment is of sufficient duration to have aggravated the condition caused by cigarette smoking; and, since there was radiological evidence of simple coal workers' pneumoconiosis, coal dust exposure could have contributed significantly to Claimant's respiratory impairment. Dr. Paranthaman expressly concluded that Claimant "has simple coal workers' pneumoconiosis in addition to pulmonary emphysema and reactive airway disease. His respiratory impairment is partly due to coal mine employment." He declared that Claimant would be unable to do his last coal mine employment as an underground worker or a truck driver. (DX 12)

Dr. Dahhan, who is board-certified in internal medicine and the subspecialty of pulmonary medicine, examined Claimant on April 14, 1998, and in a report dated April 16, 1998, noted an increased AP diameter with hyperresonancy to percussion, reduced air entry to both lungs with prolongation of the expiratory phase, but no crepitation or pleural rubs, and Claimant's use of three inhalers by way of breathing medication. He noted a smoking history of a half pack per day beginning at age twenty and ending six years prior at age sixty. His examination included medical testing, including an electrocardiogram, arterial blood gas studies at rest which showed moderate hypoxia with adequate ventilation, pulmonary function studies which showed moderately severe partially reversible obstructive ventilatory defect, lung volume measurements showing air trapping and overinflation with a residual volume of 221% of predicted, reduced diffusion capacity of 25% of predicted, carboxyhemoglobin of 1.5%, no evidence of any restrictive ventilatory abnormality, and a chest x-ray showing hyperinflated lungs consistent with emphysema, but clear lung fields, classified 0/0, with no abnormalities consistent with pneumoconiosis. He also reviewed the miner's descriptive claim information, including that related to the nature of Claimant's coal mine employment, and the assessment by Dr. Paranthaman with its supporting medical evidence. (DX 35, 47)

Dr. Dahhan concluded: 1) there is insufficient objective data to justify a diagnosis of coal workers' pneumoconiosis based on the obstructive abnormalities shown on clinical examination, obstructive abnormality on pulmonary function studies, and emphysema on chest x-ray with no radiological evidence of simple coal workers' pneumoconiosis; 2) Claimant has chronic obstructive lung disease consisting of chronic bronchitis and emphysema, based on clinical examination and physiological testing; 3) from a respiratory standpoint Claimant does not retain the physiological capacity to do his previous coal mine or comparable work because of the obstructive airway disease; 4) the cause of his pulmonary disability is his lengthy smoking habit of 1/2 pack a day for 40 years, an amount of smoking which Dr. Dahhan assessed as "more than sufficient to cause the development of centrilobular emphysema in a susceptible individual with a secondary obstructive ventilatory abnormality"; 5) Claimant's obstructive lung disease is not the result of coal dust exposure or occupational pneumoconiosis, since any industrial bronchitis would have ended since 1994 when he ceased coal mine employment. Also, the obstructive ventilatory disease with significant reversibility after the administration of bronchodilators is inconsistent with the permanent adverse effects of coal dust on a miner's respiratory system; and 6) even if there were radiological evidence of simple coal workers' pneumoconiosis, his opinion would still be that the miner's pulmonary disability is due to smoking, not coal workers' pneumoconiosis. (DX 35, 47)

Dr. Wheatley, who identified himself as Claimant's primary care treating physician, since January

15, 1998, including two hospitalizations, and who is board-certified in family practice, but admittedly not a pulmonary specialist, reported on October 5, 1998, that Claimant had responded to "medications for emphysema/asthma, and/or COPD [chronic obstructive pulmonary disease]," that he had experienced forty-five years of underground coal mine employment, and had a smoking history of a pack of cigarettes per day for an undefined period ended more than ten years prior to the report. He recorded that "the pulmonary examination is consistent with chronic obstructive pulmonary disease with interstitial markings present," which "also are consistent with coal worker's pneumoconiosis." This assessment was purportedly consistent with an unidentified radiologist's interpretation of multiple x-rays previously taken. He noted that blood gas studies disclosed CO_2 retention and that the pulmonary function studies were consistent with moderate to severe obstructive pulmonary disease with some nonrestrictive pattern. Dr. Wheatley's clinical impression, explicitly not based upon objective data such as a lung biopsy or bronchoscopy, was that Claimant has chronic obstructive pulmonary disease "probably" with a component of coal workers' pneumoconiosis. Nevertheless, Dr. Wheately stated his belief that Claimant's coal worker's pneumoconiosis was "a significant contributing element to his lung disease" (DX 94).

On October 14, 1998, Dr. Hippensteel, who is board-certified in internal medicine and pulmonary medicine and a B-reader, reviewed specified medical records, concluding that the majority of chest x-ray reports were negative, and that certain changes reflected in the chest x-ray interpretations were associated with cigarette smoking.[8] He opined that the absence of coal mine employment for the last four years precluded a diagnosis of industrial bronchitis. Dr. Hippensteel opined that the partially reversible obstructive disease without restriction was well explained by Claimant's unspecified cigarette smoking history which he characterized as a more intensive cause of bronchial inflammation and obstructive lung disease than coal dust. He declared that obstructive lung disease from cigarette smoking is typically partially reversible, as in Claimant's case, while coal workers' pneumoconiosis causes a fixed, permanent impairment that, when present, usually features both restrictive and obstructive components not evident in this case. Dr. Hippensteel thus concluded with a reasonable degree of medical certainty that Claimant is not impaired by coal workers' pneumoconiosis, and that Claimant's impairment is secondary to cigarette smoking, rather than coal dust exposure, but is severe enough to prevent his return to coal mine employment (DX 68).

Dr. Fino's medical report dated May 8, 1998, reflected a pulmonary examination on April 21, 1998, including physical examination, arterial blood gas and pulmonary function studies, and x-ray. Dr. Fino is board-certified in internal medicine and the subspecialty of pulmonary disease, and is a B-reader. He recorded a fifteen year smoking history of a half pack of cigarettes per day from 1975 to 1990, and a forty-five year coal mine employment history, twenty-five underground, ending as a truck driver hauling coal in

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[8]The professional credentials of Dr. Hippensteel are not in evidence. However, this tribunal takes judicial notice that his relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990). Likewise, his status as a B-reader is established with reference to the current List of NIOSH Approved B-Readers, which may be found, *inter alia*, at http://www.oalj.dol.gov.

1994. He noted that some of Claimant's last job involved loading the truck with a front end loader, and that the heaviest part of the job was changing tires. Dr. Fino noted breathing medication consisting of two inhalers. However, on examination Claimant's lungs were clear to auscultation and percussion on a tidal volume breath and a forced expiratory maneuver without wheezes, rales, rhonchi, or rubs. The x-ray was negative for pneumoconiosis, classified 0/0. However, spirometry revealed severe obstruction with a bronchodilator response. Dr. Fino recorded that total lung capacity was normal, but that there was air trapping, reduced diffusing capacity, normal oxygen saturation, and normal carboxyhemoglobin. The arterial blood gas studies revealed mild hypoxia and mild hypercarbia, which is excess carbon dioxide in the blood. Dr. Fino also recorded, inter alia, no history of cardiovascular disease, genitourinary problems, or diabetes, which conflicted, along with his finding of normal total lung capacity, with other medical findings in the record. Dr. Fino also reviewed Dr. Paranthaman's assessment.

Dr. Fino's diagnosis was severe obstructive lung disease with emphysema due to smoking. He explained in detail the basis for his conclusion that Claimant cannot be diagnosed with coal workers' pneumoconiosis, does not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure, but has a totally disabling respiratory impairment that would preclude his return to his last coal mine employment or comparable work. Dr. Fino reasoned that the characteristics of the obstructive ventilatory abnormality based on reduction of the FEV_1/FVC ratio in the absence of interstitial abnormality, and small airway flow more reduced than large airway flow, as well as the demonstrable reversibility with the administration of bronchodilators, are inconsistent with coal mine dust caused abnormality. Dr. Fino explained that because Claimant's total lung capacity was not reduced, the presence of restrictive lung disease and significant pulmonary fibrosis indicative of coal mine dust induced disease could be ruled out. (DX 34)

In a deposition taken on November 24, 1998, Dr. Fino declared it extremely unlikely that Claimant would have begun smoking in his forties, which would have been the case had he begun smoking half a pack per day in 1975, as Claimant had resolutely claimed. He considered beginning smoking at age twenty, as told to Dr. Dahhan, far more likely, though even at the lesser amount, he opined that Claimant could have got significant obstructive lung disease. (EX 22 at 7-8, 18-19) He testified that on examination he had not noted any wheezing or physical examination abnormalities of the lungs. (EX 22 at 9) He declared that the inhaled bronchodilators used by Claimant would have been useful for reversible conditions such as smoking and asthma, but would not have been useful for the treatment of medical or legal pneumoconiosis, because they are ineffective against symptoms due to coal mine dust inhalation.

Dr. Fino found respiratory disability based jointly on the pulmonary function tests which showed a severely reduced FEV_1, reflecting difficulty getting air into and out of his lungs, and reduction in defusion capacity which indicated emphysema. He also diagnosed hypercarbia, an increase in blood carbon dioxide level which indicates a significant, independently disabling, lung impairment reflecting destruction of more than seventy percent of viable lung tissue as nonfunctional. He explained that asthma, emphysema, or severe pulmonary fibrosis such as that caused by coal workers' pneumoconiosis, could be the cause. He declared that the pulmonary fibrosis would be a permanent condition, which would be discernible on chest x-ray as category 2/3 or greater. He ruled that out totally because of the reversibility of Claimant's pulmonary symptoms. Dr. Fino thought the emphysema was accountable for the hypercarbia because of

its destructive effect and because of wheezing which Dr. Fino had not heard, allegedly because of its variability, but which was heard by Dr. Parenthaman. (EX 22 at 10-13)

Dr. Fino also opined that the reduced defusion capacity, which measures the ability to get oxygen out of the pulmonary air sacs into the bloodstream, can be caused by the destructive effect of pulmonary fibrosis such as pneumoconiosis and of emphysema, which he opined was the cause in this case. He opined that the emphysema is consistent with the obstruction, on the one hand, and, on the other hand, the absence of pulmonary fibrosis on x-ray and the over inflated rather than reduced lung volumes were inconsistent with pulmonary fibrosis and scarring. He characterized the defusion capacity and the lung volumes together with the spirometry results as reflecting a textbook case of emphysema. He also declared the absence of decreased or underinflated lung volumes as absolutely indicative of the absence of restrictive lung disease. (EX 22 at 14-16, 22)

In excluding coal dust as a contributing factor to Claimant's respiratory impairment, notwithstanding his prolonged history of occupational exposure, Dr. Fino cited his overall evaluation and test results, the absence of symptoms of industrial bronchitis, and medical literature. He declared that the reduction in FEV_1 which the literature described in working miners was too small to be of clinical significance. (EX 22 at 17, 21-22) He also disagreed with Dr. Paranthaman's conclusion that coal dust exposure or coal mine employment aggravated the condition caused by cigarette smoking, first, because the Claimant's "huge" lung volumes, over two times normal, contradicted expectations of low lung volumes normally caused by pneumoconiosis. He noted that Dr. Paranthaman had not performed lung volume measurements, an omission which would have adversely affected his ability to assess the cause of Claimant's impairment in this case. Second, he disagreed with Dr. Paranthaman because the loss in FEV_1 projected in studies of long term underground miners, which would reflect inhalation of coal dust, would be too small to have a significant clinical effect, particularly in relation to Claimant's other pulmonary impairment. (EX 22 at 24-25, 28-29) He also opined that the x-ray readings in category 1/0 tend to be subject to question; that the reading by Dr. Lippmann described opacities uncharacteristic of pneumoconiosis; and that Dr. Narvani's reading, though positive for pneumoconiosis, was not convincing in the context of the other evidence. (EX 22 at 27-28)

Dr. Robinette, who is board-certified in internal medicine and pulmonary medicine and is a B-reader, examined the miner for an assessment of his respiratory status on January 22, 1999. He reported increased AP diameter of the chest, inspiratory crackles at both bases on auscultation, bilateral wheezes, and marked prolongation of the expiratory phase. He also reported a ten to fifteen pack year smoking history ending in the 1980's, a forty year coal mine employment history comprised of twenty-four years underground ending in 1981 as a long wall operator, followed by work as a coal hauler, driving and loading a truck and working in the coal stock piles. He identified multiple serious health problems, including severe dyspnea, diabetes, and a history of bladder cancer, as well as severe pulmonary abnormalities. (DX 94; C-4)

The results of medical tests included chest x-ray findings of expanded lungs with diffuse interstitial pulmonary fibrosis and scattered opacities consistent with pneumoconiosis, 1/1, q/t, emphysema, and axillary coalescences in pneumoconic nodules. He interpreted pulmonary function studies as showing a

decreased FVC, normal total lung capacity with mild elevation of the residual volume and severely impaired diffusion capacity at thirty-three percent of predicted. Resting blood gas studies revealed elevated pCO_2 and decreased pO_2, consistent with very severe obstructive lung disease with marked impairment of the diffusing capacity, severe hypoxemia, and hypercapnia. Dr. Robinette's recorded impression, in relevant part, was 1) coal workers' pneumoconiosis, 1/1 q, with underlying emphysema; 2) very severe obstructive lung disease with marked impairment of the diffusion capacity and intercurrent hypoxemia; 3) mild hypertensive cardiovascular disease . He concluded that Claimant is totally disabled by his pulmonary disease and severe impairment of diffusion capacity, that Claimant's totally disabling pulmonary impairment is chronic, irreversible, and will not improve, and that his coal workers' pneumoconiosis was caused by his coal mine employment. Dr. Robinette's opinion was explicitly based in part upon medical literature which he interpreted as documenting a relationship between coal dust exposure and progressive pulmonary dysfunction. (DX 94)

At his deposition on February 22, 2000, in addition to reiterating many of his prior findings, Dr. Robinette declared a preference for examining patients and interpreting his own diagnostic studies without the distraction of other medical opinions or records, in order to be free of bias in evaluating a patient's x-rays, occupational history, and medical history. Dr. Robinette opined that Claimant's air flow obstruction was so unusually severe that it had to be caused by more than the severe emphysema, which was disclosed by x-ray, consistent with Claimant's twenty-four years underground occupational exposure. He opined that it could be explained by medical literature indicating that such impairments could be caused by coal dust exposure from coal mine employment. In this regard, the disparity between Claimant's somewhat elevated total lung capacity and his diffusion capacity, which was severely reduced to thirty-three percent of predicted, reflected a pulmonary disability reasonably attributable to Claimant's coal workers' pneumoconiosis due to coal mine employment as well as from emphysema, because of his limited smoking history, his substantial coal mine employment history, and pulmonary function study results. While recognizing the normal textbook premise that simple coal workers' pneumoconiosis is not associated with a significant pulmonary impairment, Dr. Robinette referred to discussions in medical literature indicating that even with minimal dust exposure some miners can have a profound impairment of their ventilatory capacity associated with emphysematous changes which may not be related to a significant smoking history. Dr. Robinette concluded that Claimant had developed severe emphysema and severe airflow obstruction from his coal dust exposure. (CX 4).

Dr. Lockey, who is board-certified in internal medicine, the subspecialty of pulmonary disease, and occupational medicine, reviewed specified medical evidence on January 26, 1999.[9] He concluded that there were no clinical findings consistent with coal workers' pneumoconiosis; that the majority of chest x-ray readings were negative; and that the positive chest x-ray readings reflected the presence in low perfusion of irregular opacities in the middle and lower lung zones, not typical for coal workers'

[9]Although the record does not contain the credentials of Dr. Lockey, this tribunal takes judicial notice of Dr. Lockey's qualifications as listed on the worldwide web, American Board of Medical Specialties, Public Education Program, Verification of Certification Results, at *www.abms.org*. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

pneumoconiosis which, he observed, is usually indicated by rounded opacities in the upper lungs. He opined that the pulmonary function studies demonstrated severe airway obstruction with air trapping consistent with emphysema, which was also disclosed by chest x-rays. He also noted a significant bronchospastic component because of Claimant's significant response to bronchodilators as to both FEV_1 and FVC, and suggested that the discrepancy in the diffusion capacity results from April 14 to April 21, 1998 might reflect partially reversible airways obstruction. (EX 18)

Dr. Lockey opined that the severe airway obstruction with air trapping, and chest x-ray evidence of emphysema is secondary to cigarette smoking. He opined that Claimant's bronchospastic component is most likely secondary to airway hyperreactivity which can be associated with cigarette smoking and/or a pre-existing asthmatic condition. He opined that Claimant's decreased pO_2 and intermittently increased pCO_2 are a reflection of his severe airway obstruction and air trapping with alveolar hyperventilation. He found no consistent clinical findings compatible with coal workers' pneumoconiosis or other pulmonary disorders related to coal and/or rock dust exposure. He opined that the miner is totally disabled from his usual coal mine or comparable work due to his respiratory impairment, but that the impairment is essentially secondary to emphysema attributable to cigarette smoking and is not due to coal or rock dust exposure or to pneumoconiosis. (EX 18)

Conclusions of Law and Discussion

Existence of Pneumoconiosis and Disability Causation

Section 718.202 provides that the existence of pneumoconiosis may be established pursuant to the criteria set forth in subsections (a)(1) through (a)(4). With respect to §718.202(a)(1), the record contains forty-eight interpretations of nine x-rays. Seven of these interpretations are positive for pneumoconiosis, but forty-one are negative under the classifications set forth in §718.102(b). Inasmuch as the x-ray evidence is in conflict, greater weight is properly assigned to the opinions of the physicians who are both board-certified radiologists and B-readers, than to the opinions of the physicians who are only B-readers. *Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984). Seven physicians with the greater qualifications read various x-rays as negative for pneumoconiosis thirty-six times, while five physicians with those qualifications read the various x-rays as positive just six times. The overwhelming numerical superiority of the negative readings over the positive readings in this case precludes proof of the existence of pneumoconiosis by a preponderance of the x-ray evidence pursuant to §718.202(a)(1). *Director, OWCP v. Greenwich Collieries*, 114 S.Ct. 2251, 2259 (1994).

There is no biopsy evidence of record, and so Claimant has not established the existence of pneumoconiosis pursuant to §718.202(a)(2). The presumptions provided by §§718.304, 718.305, and 718.306 are inapposite because there is no evidence of complicated pneumoconiosis, because the claim was filed after 1981, and because the miner is living. The presence of pneumoconiosis, therefore, is not established pursuant to §718.202(a)(3).

Under §718.202(a)(4), the existence of pneumoconiosis may be established if a physician exercising sound medical judgement based on objective medical evidence and supported by a reasoned

medical opinion, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Both chronic bronchitis and chronic obstructive pulmonary disease qualify as "legal" pneumoconiosis, if caused by coal mine employment. §718.201 Drs. Dahhan, Fino, Hippensteel, and Lockey found no clinical or other basis for a diagnosis of coal workers' pneumoconiosis. Dr. Paranthaman's and Dr. Wheatley's assessments were equivocal and unpersuasively reasoned. Only Dr. Robinette diagnosed coal workers' pneumoconiosis based exclusively on the results of his own examination and testing, which was inconsistent in significant respects with other evidence of record. Since the preponderance of the relevant evidence weighs against the existence of coal workers' pneumoconiosis, the issue of whether it was caused by Claimant's extensive coal mine employment pursuant to §718.203(b) is moot.

If the existence of pneumoconiosis from coal mine employment were assumed to have been proved, Claimant would still be required to prove total disability attributable thereto in order to establish entitlement to black lung benefits. Under Section 718.204(c), the criteria for determining whether a miner is totally disabled are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right-sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinion of a physician relying upon medically accepted clinical laboratory and diagnostic techniques. All the physicians who have examined Claimant or reviewed his medical records in this case agree that Claimant has a disabling pulmonary condition. That finding is supported by the qualifying pulmonary function studies and qualifying blood gas studies under the applicable regulatory standards. However, Drs. Dahhan, Hippensteel, Fino, and Lockey concluded that Claimant's pulmonary condition was related to his exposure to cigarette smoke and not to coal dust from his coal mine employment. These physicians noted specific findings on chest x-ray, physical examination, and pulmonary testing in support of their reasoned conclusions. On the other hand, Drs. Paranthaman and Robinette concluded less persuasively that Claimant's pulmonary condition was related to coal dust exposure in addition to his history of cigarette smoking. Dr. Wheatley did not discuss the miner's smoking history, but associated the miner's pulmonary condition with his exposure to coal mine dust in an opinion essentially unsupported by either adequate objective evidence or persuasive reasoning.

Dr. Dahhan's is a comprehensive reasoned opinion based upon his observations and testing resulting in extensive and particularized objective evidence, as well as review of Dr. Paranthaman's report with its supporting evidence. It reflects a categorical conclusion that Claimant does not have coal workers' pneumoconiosis or lung disease related to coal dust exposure, and, therefore, could not contribute to his respiratory impairment. His conclusion essentially reflected the manifestations of Claimant's severe obstructive pulmonary disease identified clinically by x-ray, and by pulmonary function studies as centrilobular emphysema explainable by a forty year, half a pack of cigarettes per day smoking history, and the absence of x-ray evidence of pneumoconiosis and evidence of restrictive ventilatory abnormality, or permanency characteristic of the effects of coal dust. Dr. Dahhan is a qualified pulmonary specialist, and, consequently, his qualifications and his reasoning make his opinion persuasive.

In contrast, Dr. Paranthaman concluded that Claimant's respiratory impairment was primarily due to emphysema and reactive airway disease caused by cigarette smoking, but aggravated by sufficient years

of coal mine exposure. Dr. Robinette opined that the combination of values on the total lung capacity testing and diffusion testing indicated that Claimant was disabled by both pulmonary emphysema and coal workers' pneumoconiosis. However, Dr. Dahhan opined that Claimant is totally disabled by his pulmonary condition, but that there was insufficient evidence of pneumoconiosis or any other pulmonary condition due to coal dust exposure for the pulmonary disability to be related other than solely to Claimant's smoking habit. Because Claimant's values improved on the use of bronchodilators, which is inconsistent with the permanent adverse affects of a coal dust induced pulmonary condition, Dr. Dahhan concluded, based on the obstructive abnormality disclosed on clinical examination, the obstructive abnormality disclosed on pulmonary function study testing, and the findings of emphysema on chest x-ray with no evidence of simple coal workers' pneumoconiosis, as well as the reversibility on the use of bronchodilators noted above, that Claimant's pulmonary disability was due to his smoking.

Dr. Hippensteel's opinion, likewise, is a reasoned assessment by a qualified pulmonary specialist, though based on a review of specified but comprehensive medical records pertaining to the Claimant. Like Dr. Dahhan, he concluded categorically that the indicia of coal workers' pneumoconiosis were not present. He observed that x-ray evidence of the disease was not evident. He also opined that the partially reversible obstructive disease without restriction is more consistent with cigarette smoking than coal dust exposure. Consistent with Dr. Dahhan's findings he opined that obstructive lung disease from cigarette smoking is typically partially reversible, as demonstrated in this case, while coal workers' pneumoconiosis is a fixed condition. In addition, Dr. Hippensteel noted that coal workers' pneumoconiosis is both a restrictive and obstructive lung impairment, and that this case involves only obstructive impairments. And, though he did not mention emphysema, he opined unequivocally that Claimant's disabling pulmonary impairment, related to partially reversible obstructive disease without restriction, was more than adequately explained by Claimant's smoking history, not coal dust exposure. Like Dr. Dahhan's opinion, and generally consistent with it, Dr. Hippensteel's opinion is persuasive because of his qualifications and his reasoning.

Dr. Wheatley's equivocal opinion is plagued with inconsistencies, inaccuracies, and other defects. Significantly, he conceded that he is not a pulmonary specialist. His recorded forty-five year underground coal mine employment history is overstated; the smoking history is poorly defined and inconsistent with other evidence of record; his reasoning is vague and elusive and not clearly related to the limited objective evidence that he only identified in general terms; and his conclusion regarding the existence of coal workers' pneumoconiosis is equivocal. Among other things, it is not clear what testing Dr. Wheatley performed or used. Dr. Wheatley conceded that he did not have objective evidence that he apparently thought he needed to make a definitive diagnosis. His relationship with Claimant was relatively short and poorly defined, as was the described treatment, so that his status as a treating physician does not add significantly to his credibility. Dr. Wheatley's opinion therefore does not tend to prove persuasively either the existence of pneumoconiosis or total disability attributable thereto.

Dr. Paranthaman's assessments contained in his examination report and subsequent explanatory follow up opinion are too equivocal and deficient in reasoning to be given significant probative weight in this case. He did unequivocally find Claimant to be totally disabled and unable to return to his former coal mine or other comparable work because of his pulmonary impairment. Dr. Paranthaman attributed Claimant's pulmonary emphysema *principally* to his history of cigarette smoking, but did not explicitly identify any

other contributing cause. He identified no cause for the reactive airway disease, which he never defined. Based on his own examination and x-ray reading, he did not initially diagnose pneumoconiosis. Although he did not identify coal dust exposure as a cause of either the emphysema or the reactive airway disease, he initially declared that these conditions *could* be aggravated by forty-four years of coal dust exposure, "if documented."

Subsequently, however, after reviewing two positive, 1/0, x-ray interpretations by Drs. Navani and Lippman, who are B-readers, Dr. Paranthaman concluded that there was evidence of simple pneumoconiosis. But, despite this evidence, he declared again, in effect, that the primary cause of Claimant's pulmonary cause of Claimant's emphysema and reactive airway disease was not coal dust exposure. Indeed, he declared that the severity of the emphysema and the extent of improvement after bronchodilators were administered was "uncommon" in cases of pneumoconiosis. Notwithstanding the District Director's reduced assessment of coal mine employment to sixteen years, he still opined that it was enough to have aggravated the conditions caused by cigarette smoking. He did not opine, however, that it actually did aggravate the condition or explain how he could tell. Having thus concluded that Claimant has simple coal workers' pneumoconiosis as well as pulmonary emphysema and reactive airway disease, Dr. Paranthaman simply declared without further explanation that Claimant's respiratory impairment was partially due to coal mine employment. The extent of such effect, however, was undefined, and could have been *de minimis*. Thus his opinion, ultimately, was too equivocal and inadequately reasoned to establish causation by coal mine dust or employment.

Dr. Robinette expressly based his conclusion on Claimant's unverified smoking history of approximately fifteen pack years, which he characterized as "minimal," coal mine employment history, and the results from his pulmonary function study. Dr. Robinette explained at his deposition that Claimant's total lung capacity value should be in the range of 220 to 230 if emphysema were the only cause of the diffusion impairment. Since the value was 161, Dr. Robinette opined that it demonstrated that Claimant also had an impairment due to coal workers' pneumoconiosis. However, Dr. Dahhan's examination included lung volume measurements reflecting a huge overinflation of 221%. While Dr. Robinette expressly eschewed review of other medical records, purportedly to avoid bias, he also insulated himself from other available information such as Dr. Dahhan's measurements which might have established by Dr. Robinette's own analysis that emphysema was the only cause of the diffusion impairment.

Moreover, Dr. Robinette assumed an apparently understated smoking history of ten to fifteen pack years, not inconsistent with that recorded by Dr. Paranthaman, but Dr. Dahhan assumed a twenty pack year history based on consumption of a half a pack per day for forty years, and Dr. Fino considered an asserted fifteen year history of half a pack per day from 1975, beginning when Claimant would have been over forty to 1990, as likely to be substantially understated. Dr. Hippensteel and Dr. Wheatley did not refer to finite smoking histories. Dr. Lockey, who reviewed medical records, seems to have assumed a twenty year history of cigarette smoking, while noting Dr. Dahhan's recorded history of half a pack for forty years beginning at age twenty and Dr. Fino's recorded history of half a pack for fifteen years.

While certain objective notations by Dr. Fino regarding the state of the Claimant's health, which are not crucial or relevant to the issues in this case, are inconsistent with seemingly reliable observations by

other physicians, they are not deemed sufficiently material to impair the credibility of his assessment of Claimant's pulmonary condition. He was an examining physician, and his reasoning on deposition based explicitly on his examination and extensive testing is persuasive and generally consistent with or effectively explanatory of the other persuasively reasoned medical opinions in the record by Drs. Dahhan, Hippensteel, and Lockey. While there is some difficulty reconciling his own finding of normal total lung capacity on the basis of his own examination with his apparent acceptance of Dr. Dahhan's findings of a "huge" total lung capacity, Dr. Fino's qualifications as a pulmonary specialist and the quality of his explanation for Claimant's pulmonary condition based in significant part on that aspect of Claimant's pulmonary condition are persuasive and credible. (DX 34; EX 22)

Dr. Lockey provided a well reasoned opinion, based on his review of medical records, which credited the majority of chest x-ray readings, which were negative, and noted the significant response to bronchodilators which showed a significant bronchospastic component to Claimant's pulmonary condition associated with cigarette smoking. Dr. Lockey also observed that the positive x-ray readings reflected irregular opacities in locations atypical of coal workers' pneumoconiosis. Thus, Dr. Lockey's conclusion that the medical evidence, including the positive x-ray reports, the negative x-ray reports, and the results of pulmonary function study testing and blood gas study results, were not consistent with coal workers' pneumoconiosis is generally consistent with, and reinforces, the other persuasively reasoned opinions, and is inconsistent with Dr. Robinette's, in assessing the evidence of coal workers' pneumoconiosis and the causes for Claimant's pulmonary disability. Thus, a substantial preponderance of the opinions by the best qualified physicians make clear that Claimant's disabling pulmonary impairment is not attributable to coal mine dust or employment, and that he is not entitled to black lung benefits.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for representation services rendered to him in pursuit of his claim.

ORDER

The claim of Lincus Baker for black lung benefits under the Act is denied.

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EDWARD TERHUNE MILLER
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.